

Substance Abuse

GOAL

Reduce substance abuse, including tobacco use and exposure to secondhand smoke, to protect the health, safety, and quality of life for all, especially children.

Overview

Substance abuse and addiction are among society's most pervasive health and social concerns. In Maine, it is estimated that substance abuse costs over \$1 billion in lost wages, medical expenses, social services, and criminal justice expenditures. Tobacco contributes an additional one-half billion in health care costs alone. The devastating emotional and social impact on one's family, friends, and community from alcohol, illicit drug, and tobacco addiction is immeasurable.

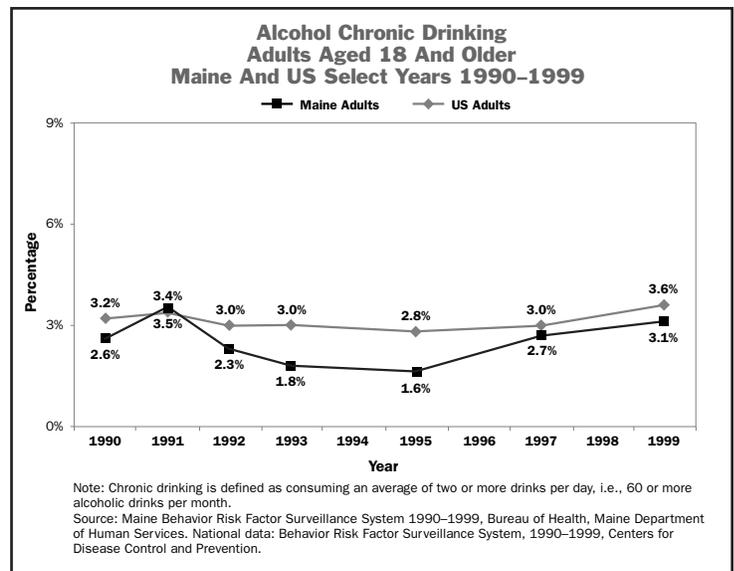
Alcohol

Alcohol-related diseases and injuries claim the lives of an estimated two people per day in Maine. As importantly, alcohol's effects are far-reaching – not only disabling the person who is alcohol dependent or who abuses alcohol but affecting, even devastating, their family, co-workers, and friends.



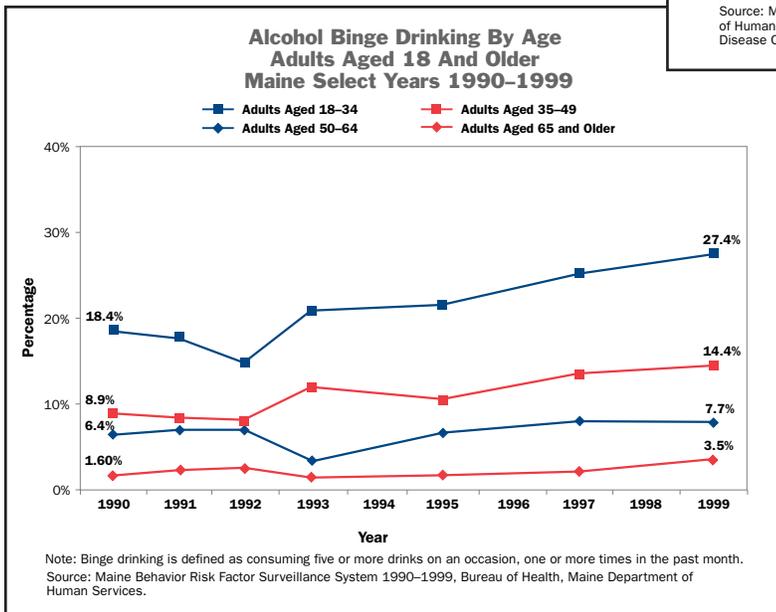
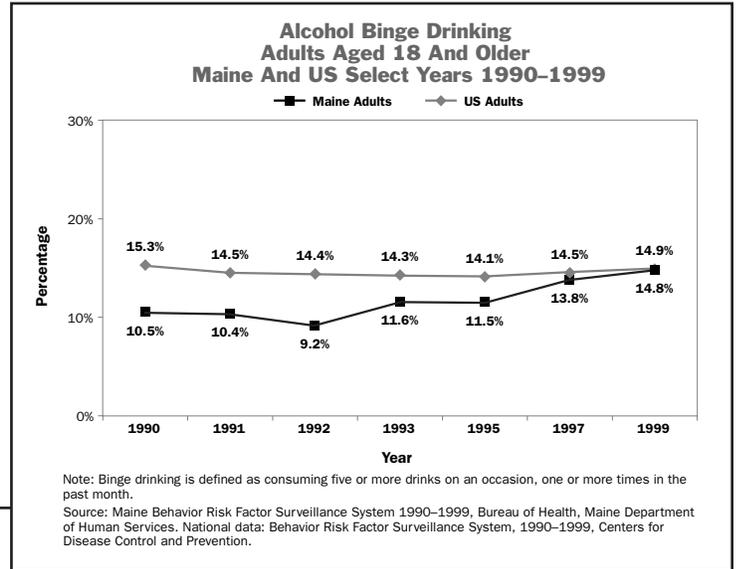
Alcohol use and dependence is very common.

Nationally, 44% of adults report drinking at least 12 drinks over the past year. Of these current drinkers, 10% meet the criteria for alcohol dependence and an additional 7% meet the criteria for alcohol abuse.



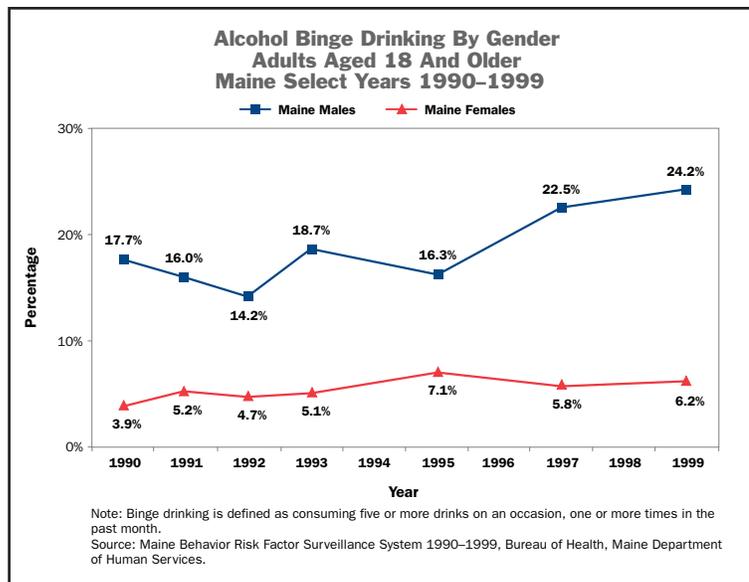


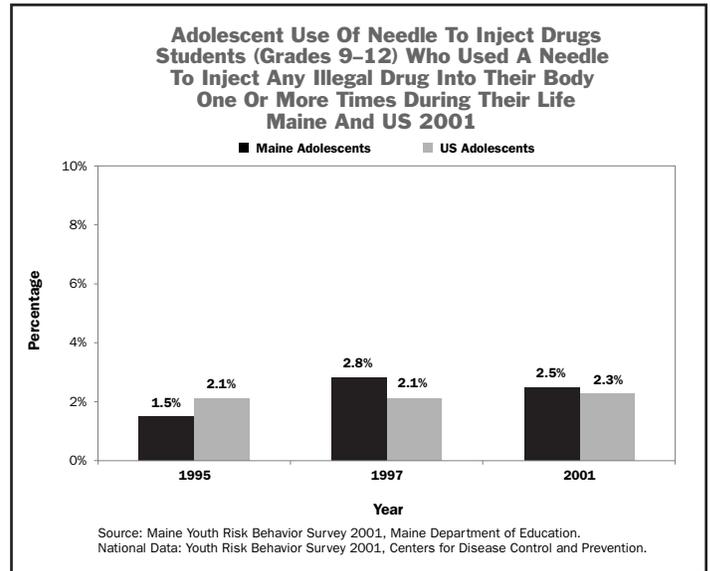
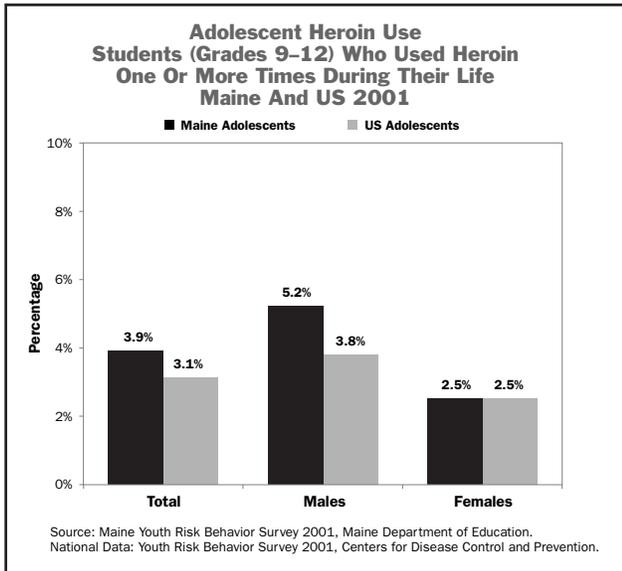
Although light to moderate drinking (generally 1–2 drinks per day, depending on body mass index) has been shown to have some beneficial effects on the heart, particularly for men and women over age 45, this same amount of drinking at other times can be very harmful. For instance, alcohol use, even light to moderate use, during pregnancy can be harmful to the fetus. Additionally, even small amounts of alcohol can impair one’s motor skills and is associated with a higher



risk of injury and death from operating a vehicle.

Long-term heavy drinking is associated with high blood pressure; heart disease; stroke; cancers of the mouth, throat, larynx, esophagus, colon, and breast; cirrhosis and other liver disorders; worsening of hepatitis C. Alcohol use is linked to a substantial portion of injuries and deaths from motor vehicle crashes, falls, fires, drownings, homicides, suicides, domestic violence, child abuse, and high-risk sexual behavior.





According to Maine’s Office of Substance Abuse, oxycontin appears to serve as a gateway drug to heroin. Its original attraction is that it is a prescription drug with a specific and accurate dose. When oxycontin users become addicted and tolerant, the negative images of heroin are no longer a barrier to trying it. Heroin is also often more available than oxycontin. Indeed, it appears that oxycontin addiction has been increasing over the past six years, and more recently it appears there has been a surge in heroin addiction, even in northern parts of the State.

Illicit Drugs

Although there has been an overall decline in illicit drug use over the last three decades, one-third of all Americans have used an illicit drug at sometime in their lifetime. Of these, 90% used marijuana, 50% cocaine, and an increasing percentage have used methamphetamine. In Maine, recent illicit drugs that are on the rise include oxycontin, a prescription opioid, as well as heroin. During 2001 and 2002 in Maine there has been an alarming and dramatic increase in the numbers of reports of young people dying from illicit drug use.



Use of illicit drugs is associated with serious consequences such as injury, crime, domestic violence, lost workplace productivity, STDs including HIV, hepatitis B and C, a variety of other illnesses, and death. In addition, a substantial number of illicit drug users have co-occurring chronic mental health disorders.

Tobacco

Many are calling the twentieth century the Tobacco Century. One hundred years ago few people were addicted to tobacco, since cigarettes were hand-rolled, relatively expensive, and not significantly marketed. Because of the mass production and mass marketing of tobacco that began in the 1910s, a tobacco epidemic began, needlessly killing millions. Today, about one-quarter of all adults and high school students in Maine are



PARTNERSHIP FOR A TOBACCO-FREE MAINE GOALS

- To prevent youth and young adults from starting to use tobacco
- To motivate and assist tobacco users to quit
- To protect the public from the hazards of secondhand smoke



Calling All Quitters



- To identify and eliminate disparities related to tobacco use among population groups

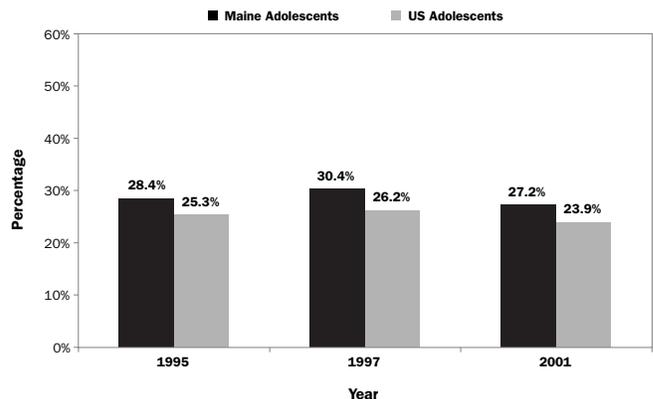
PROGRAM COMPONENTS INCLUDE:

- State infrastructure for addressing tobacco prevention and control
- Multimedia and public awareness campaigns
- Community programs
- School programs
- Surveillance and evaluation
- Enforcement of tobacco laws
- Statewide system of tobacco treatment services
- Statewide youth advocacy network
- Local youth advocacy programs



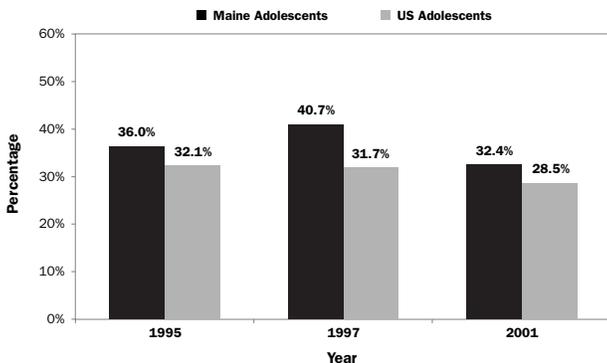
addicted to tobacco. National studies show that one-third of youth who experiment with tobacco will become addicted, and one-third of youth who smoke will die from a tobacco-related death. It is estimated that of those adults who continue to smoke, over half of them (55%) will die from their tobacco addiction (CDC, MMWR, November 8, 1996). Nicotine, the active ingredient in tobacco, is as addictive as heroin. Yet, it is a legal substance that the tobacco industry spends an estimated \$8 billion per year advertising; many of those dollars aimed at our youth and young adults.

Adolescent Marijuana Use
Adolescents (Grades 9–12) Who Used Marijuana One Or More Times During The Past 30 Days
Maine And US 1995, 1997, 2001



Source: Maine Youth Risk Behavior Survey 1995, 1997, and 2001, Maine Department of Education. National Data: Youth Risk Behavior Survey 1995, 1997, and 2001, Centers for Disease Control and Prevention.

Illegal Drugs On School Property
Students (Grades 9–12) Who Were Offered, Sold, Or Given An Illegal Drug On School Property By Someone During The Past 12 Months
Maine And US Select Years 1995–2001



Source: Maine Youth Risk Behavior Survey 1995, 1997, and 2001, Maine Department of Education. National Data: Youth Risk Behavior Survey 1995, 1997, and 2001, Centers for Disease Control and Prevention.

What is the result of this mass production and mass marketing? Massive disability and death are the result. Tobacco disables and kills people through a number of diseases, among them: heart disease; stroke; numerous cancers such as lung, throat and bladder cancer; emphysema; asthma; diabetes; sudden infant death syndrome; low birth weight; childhood asthma; childhood ear infections; and childhood pneumonia. Each day in Maine, an estimated seven people die from a tobacco-related death: seven people who suffered from a tobacco-related illness, most of them for a long time with resulting disabilities; seven families who are grieving the early loss of a loved one; seven Maine people who will be surely missed.

Prevention and Treatment

There is good news. Effective prevention and treatment interventions are more available today for various substances than just a few years ago. Effective prevention strategies are very similar for all substances, including tobacco, and generally include those that strive to change the cultural beliefs about drugs; to enforce existing laws, especially those pertaining to youth access for alcohol and tobacco; to educate about the effects of different substances; to counter the mass marketing by the alcohol and tobacco industries; to provide healthy alternative activities for our youth; and to reduce the secondhand effects of drugs.



Effective treatment programs vary greatly among individual drug users, as well as among different substances. However, recognizing this and developing these tailored treatment programs is something Maine is striving for.

Strategies



- **Decreasing the Supply:** Decreasing the availability of substances through promotion and training of responsible retailing practices, as well as random unannounced inspections using minors for the purchase of tobacco and alcohol; identifying and eliminating social sources of youth access to tobacco, alcohol, and illicit drugs; and using law enforcement efforts to decrease the supply of illicit drugs are some examples.
- **Decreasing the Demand:** Strategies include increasing the proportion of youth participating in positive skill-building activities such as organized sports, music, art activities; and increasing the price of tobacco and alcohol through excise taxes.
- **Environmental Changes:** Implementing interventions to reduce secondhand effects of drugs such as making environments smoke-free, and providing support groups for family members and friends of those who are addicted to alcohol and drugs; changing the cultural norm and attitudes toward substances to one that says “everyone has better things to do than drugs, alcohol, tobacco” and that makes it uncool to drive drunk; banning or restricting the location of stores that sell drug paraphernalia; or encouraging alcohol and chemical-free dance clubs are all examples.
- **Education:** Education strategies include strengthening refusal skills for youth that helps them reject peer pressure to use alcohol, tobacco, and illicit drugs; and educating youth and adults about the types of drugs being used in the population and their toxic effects.
- **Initiatives for Those at Risk:** These include prevention interventions focused on those at risk such as at-risk youth and adults who have a history of binge drinking or driving under the influence.
- **Treatment Initiatives:** Assuring easy access to appropriate treatment for alcohol abuse, illicit drug use, and tobacco addiction are some examples.



Health Disparities

(Populations at risk for substance abuse and tobacco use, based on national data in *Healthy People 2010*)

- **Adolescents and young adults** (more likely to die in an alcohol-related motor vehicle crash; higher rates of tobacco use)
- **Older people** (higher risks for alcohol-related problems)
- **Adolescent boys** (more likely to use spit tobacco)
- **Men** (more likely to die in an alcohol-related motor vehicle crash; more likely to be tobacco addicted)
- **People with co-occurring disorders such as mental health disorders** (often cannot access appropriate substance abuse treatment)
- **Sexual minorities** (more likely to be tobacco addicted)
- **Low socioeconomic status** (more likely to die from cirrhosis or from a drug-induced death; more likely to be tobacco addicted)
- **Native Americans** (higher rates of deaths due to alcohol-related motor vehicle crashes and cirrhosis; higher rates of alcohol or illicit drug and alcohol binge drinking during the past 30 days; higher proportion of adults who exceed guidelines for low-risk drinking; more likely to be tobacco addicted)
- **White and Hispanic adolescents** (more likely to use alcohol)
- **White adolescents** (more likely to use illicit drugs and tobacco)
- **White adults** (more likely to use alcohol and tobacco)
- **White and African-American adults** (more likely to use any illicit drugs)

Objectives

Objective numbers are *Healthy People 2010* objective numbers.

- **26–23 (Developmental) Increase the number of communities using partnerships or coalition models to conduct comprehensive substance abuse prevention efforts.**

The Office of Substance Abuse currently funds substance-abuse prevention efforts across Maine with Fund for a Healthy Maine (Maine's share of the National Tobacco Settlement) and Federal funds. This objective should be measurable in the near future.

A comprehensive program of interventions at the community level is crucial to effective substance abuse prevention, since they enable communities to address issues related to their environments, not just their at-risk populations. Improving the environment means changing local ordinances and policies, coordinating local prevention services, increasing resident participation, communicating with local media, and addressing numerous environmental factors that lead to putting people at risk for substance abuse. Effective community partnerships commonly share a community-wide vision, a strong core of community partners, an inclusive and broad membership, an ability to avoid or resolve conflict, local staff with low turnover, and a large array of locally-tailored prevention programs that empower residents to take action.

• **27-10 Reduce the proportion of nonsmokers exposed to secondhand smoke.**

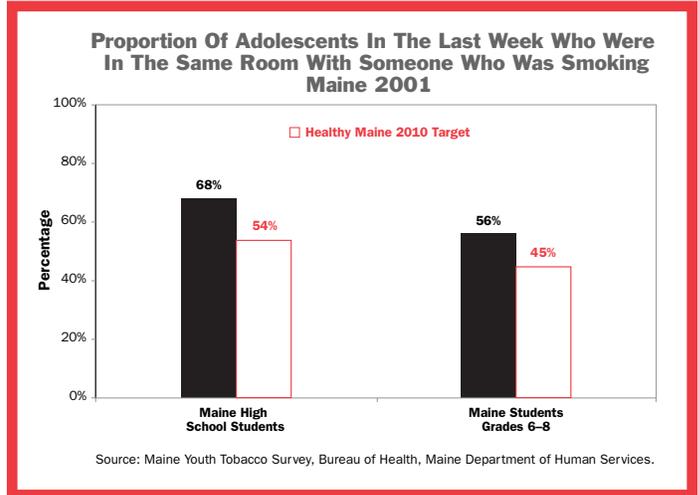
27-10a Increase the number of public indoor and outdoor places that are legally protected from secondhand smoke.

(see insert below)

27-10b Reduce the proportion of Maine adolescents who were in the same room with someone who was smoking.

Maine High School Students
Healthy Maine 2010 Baseline: 68%
Healthy Maine 2010 Target: 54%

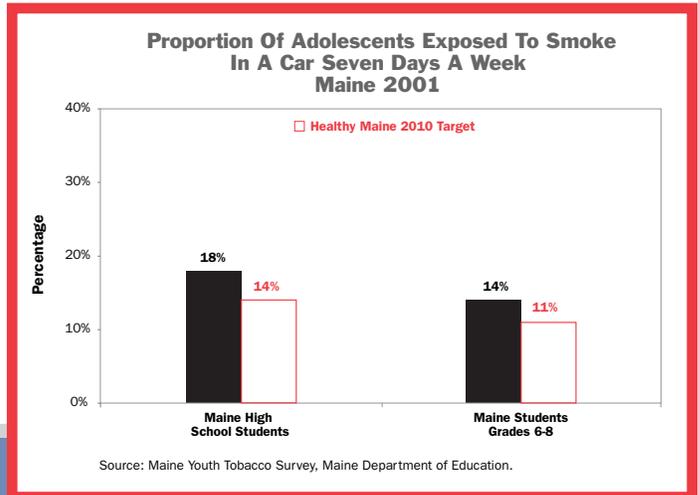
Maine Students Grades 6-8
Healthy Maine 2010 Baseline: 56%
Healthy Maine 2010 Target: 45%



27-10c Reduce the proportion of Maine adolescents exposed to smoke in a car seven days a week.

Maine High School Students
Healthy Maine 2010 Baseline: 18%
Healthy Maine 2010 Target: 14%

Maine Students Grades 6-8
Healthy Maine 2010 Baseline: 14%
Healthy Maine 2010 Target: 11%



Most public indoor places in Maine are smokefree, including workplaces.

Major exceptions are:

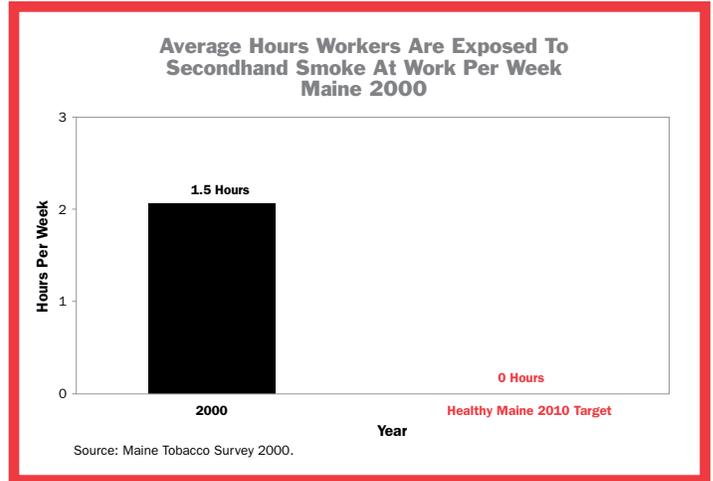
- **class A lounges and taverns (licenses that do not allow unaccompanied minors under age 21)**
- **pool halls when minors under age 18 are allowed**
- **licensed beano or bingo halls when game is being played**
- **tobacco stores under 2,000 square feet**
- **motel and hotel rooms**



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27-10d Reduce the average hours Maine workers are exposed to secondhand smoke at work.

Healthy Maine 2010 Baseline: 1.5 Hours Per Week
Healthy Maine 2010 Target: 0.0 Hours Per Week



27-10e Increase the proportion of Maine adults who do not allow smoking in their home.

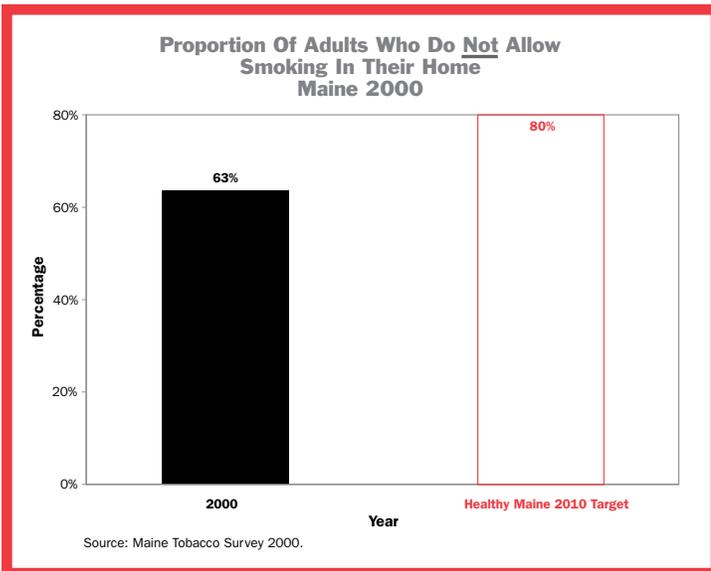
Healthy Maine 2010 Baseline: 63%
Healthy Maine 2010 Target: 80%

National surveys indicate that 65% of nonsmokers, age four years and older 1988–1994, were exposed to tobacco smoke as measured by blood cotinine levels. Data sources in Maine to measure this objective are from Maine Tobacco Surveys.

Secondhand smoke is the unfiltered smoke coming off the tip of the cigarette and the sidestream smoke exhaled by the smoker. Secondhand smoke is also found with pipe and cigar smoking. Since it is mostly unfiltered, secondhand smoke contains higher concentrations of many of the harmful chemicals found in cigarette smoke. Exposure to secondhand smoke is associated with unhealthy low birth weight, sudden infant death syndrome (SIDS), childhood pneumonia, childhood and adult asthma, childhood ear infections,

heart disease, emphysema, and lung cancer. Secondhand smoke is classified by the Environmental Protection Agency and others as a Class A carcinogen, in the most toxic class of all cancer-causing chemicals – that for which there is no safe human exposure.

Exposure to secondhand smoke should decline as efforts to eliminate public smoking, to prevent tobacco addiction, and to help those who wish to quit are increasingly successful.

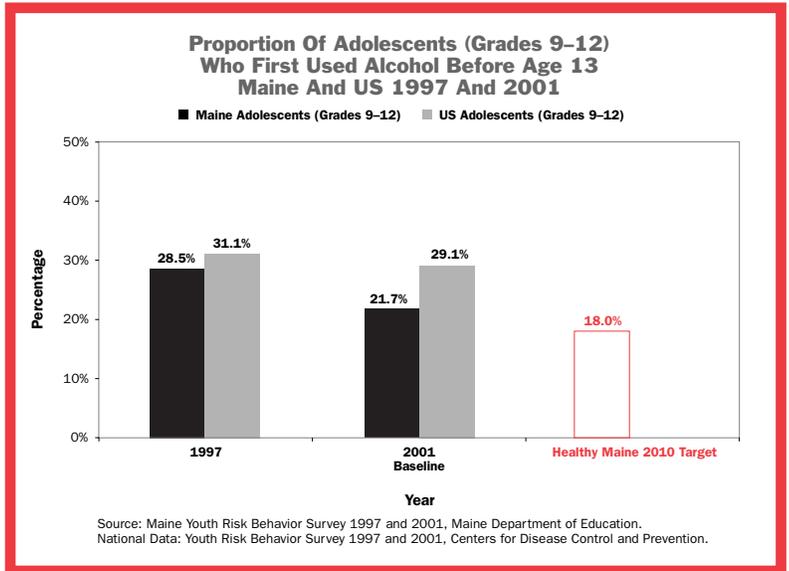


According to the 2000 Maine Adult Tobacco Survey, 88% of employed respondents said smoking is not allowed in any areas of their workplace; 6.3% said it is allowed in some areas; and 6.2% said it is allowed in all areas. Ninety-four percent (94%) said they believed secondhand smoke is harmful and 91% said they feel the public should be protected from secondhand smoke.

- **26-9 Increase the age and proportion of adolescents who remain alcohol- and drug-free.**

26-9a Reduce the proportion of Maine and US adolescents who first used alcohol before age 13.

Healthy Maine 2010 Baseline: 21.7%
Healthy Maine 2010 Target: 18.0%

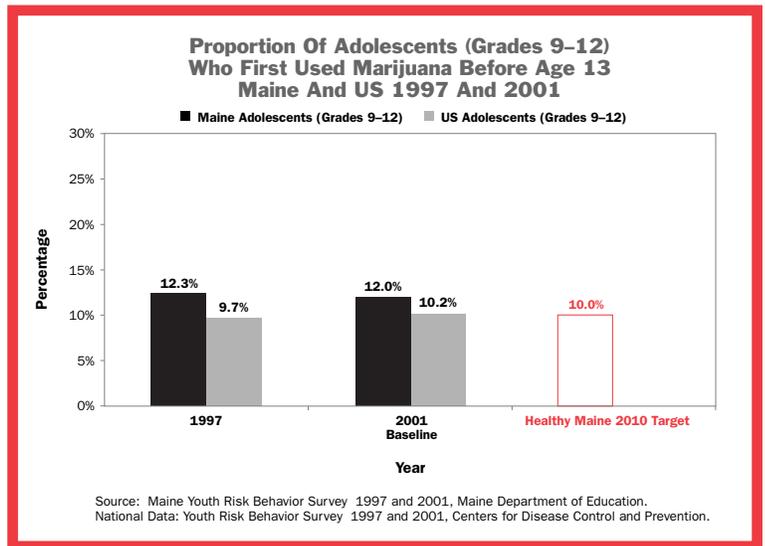


26-9b Reduce the proportion of Maine and US adolescents who first used marijuana before age 13.

Healthy Maine 2010 Baseline: 12%
Healthy Maine 2010 Target: 10%

26-9c (Developmental) Increase the proportion of Maine and US adolescents who never used any drug.

Data not available for Maine.



According to a recent Maine Office of Substance Abuse report, it appears that prescription opiates, such as oxycontin, may be one of the first drugs abused among Maine young people.

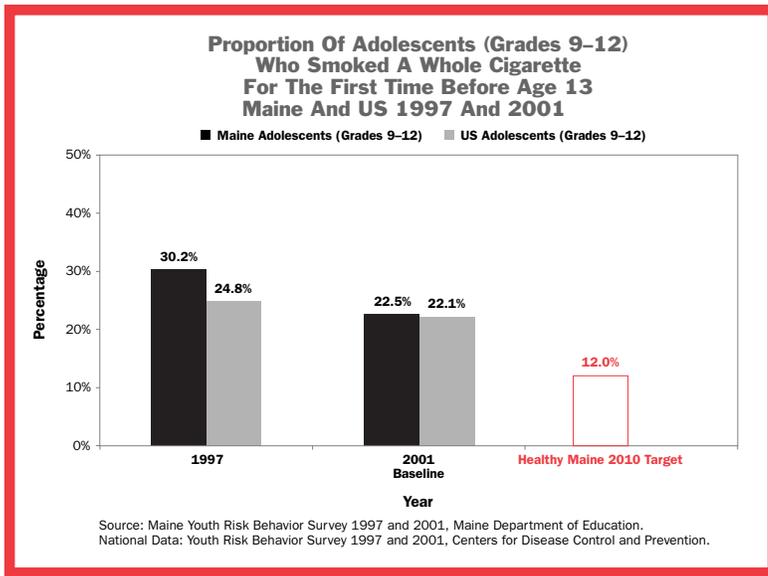
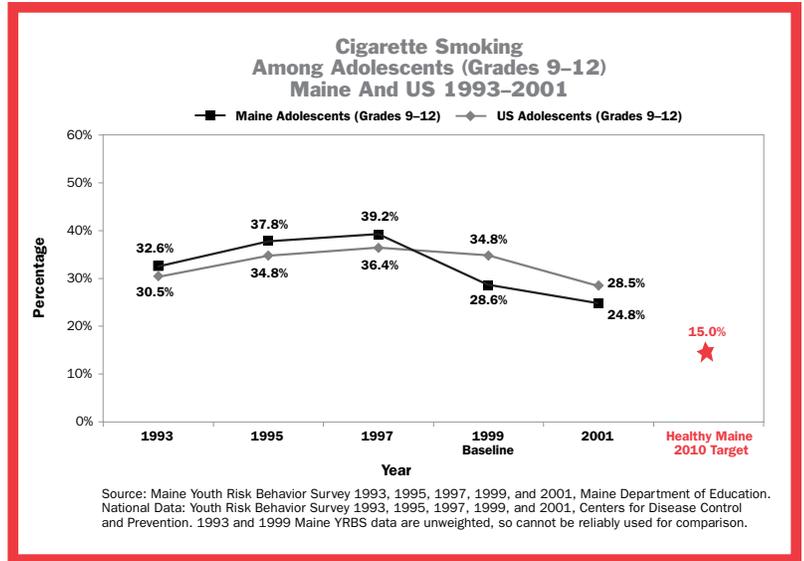
The age at onset of drinking or use of other drugs strongly predicts development of dependence. Therefore, an important prevention goal is to increase the age and proportion of adolescents who remain alcohol- and drug-free. Nationally, nearly 40% of those who start drinking at age 14 or younger will develop alcohol dependence sometimes in their lives; of those who start drinking at age 21 or older, only 10% will become dependent.



• **27-2 Reduce tobacco use by adolescents (students in grades 9-12).**

27-2a Reduce cigarette smoking among Maine and US adolescents.

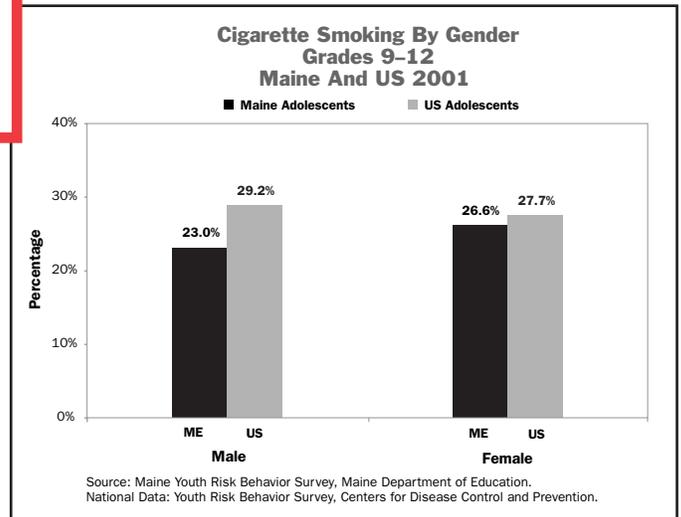
Healthy Maine 2010 Baseline: 28.6%
 Healthy Maine 2010 Target: 15.0%



27-2b Reduce the proportion of US and Maine adolescents who smoked a whole cigarette for the first time before age 13.

Healthy Maine 2010 Baseline: 22.5%
 Healthy Maine 2010 Target: 12.0%

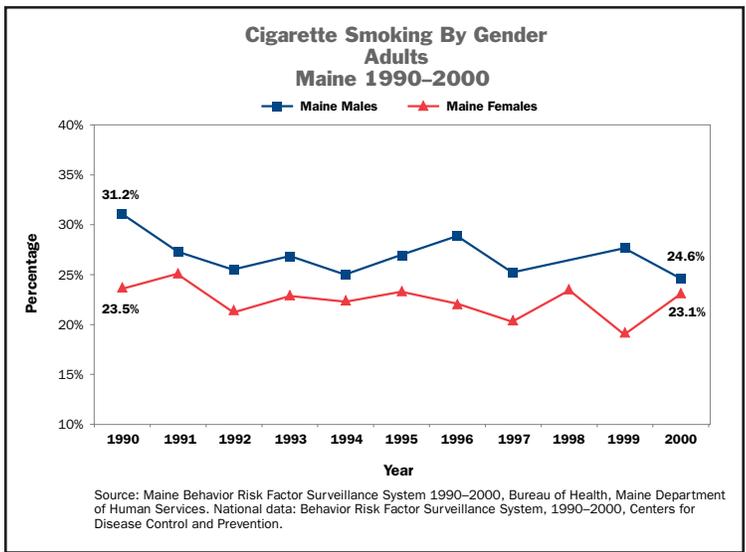
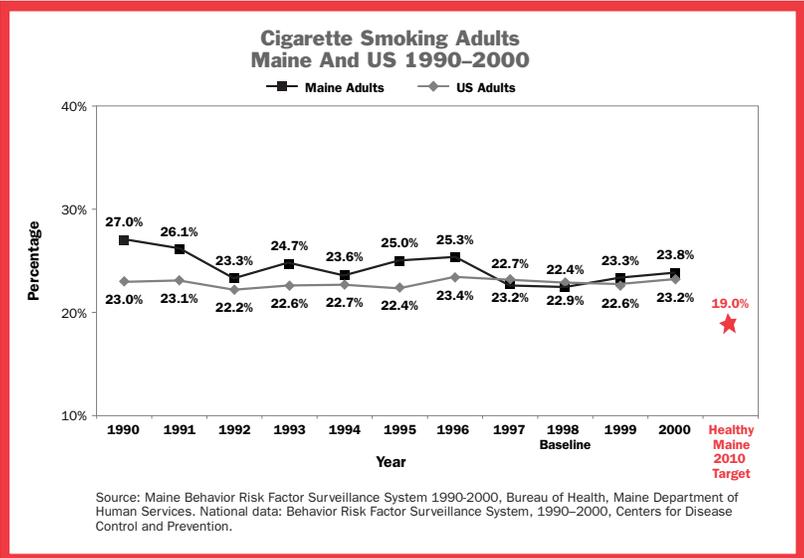
Ninety percent (90%) of adult smokers started their tobacco addiction as youth. One-third of those youth who try tobacco become addicted, and of those youth who smoke, one-third will die from a tobacco-related disease. Therefore, giving our youth the tools to prevent tobacco use is critical to reducing tobacco's burden. However, effective prevention efforts need to be in the context of a comprehensive program that includes treatment, enforcement, counter-marketing, education, and local interventions.



• **27-1 Reduce tobacco use by adults.**

Healthy Maine 2010 Baseline: 22.9%
Healthy Maine 2010 Target: 19.0%

Over three-quarters (76%) of adult smokers in Maine wish to quit, and for those who do quit, the negative health effects of tobacco are mostly reversible. For those adults who continue to smoke, over half (55%) will die from their tobacco addiction. Therefore, it is critical to assure easy access to effective treatments such as counseling and pharmaceuticals, as well as to provide smoke-free public environments in order to help reduce tobacco's burden among adults.



Maine's Tobacco HelpLine provides counseling to any Maine resident who wants to quit using tobacco. It also provides access to pharmaceuticals for those who qualify. Funded with tobacco settlement dollars, the program is free and confidential.

HelpLine counselors help boost the caller's confidence and give strategies to get through the tough times. Callers are given guidance and help tailored to their own individual needs. Counselors discuss a variety of issues such as how to develop coping skills while off tobacco. If a caller agrees, a series of counseling sessions will be arranged and written materials are sent out.

As of August 1, 2002, Nicotine Replacement Therapy (NRT) has become available through the HelpLine at no charge for eligible callers. Callers are eligible for NRT, if they have no health insurance or no insurance coverage for tobacco treatment medication or programs. The NRT consists of nicotine gum and the nicotine patch.

The HelpLine number is 1-800-207-1230.



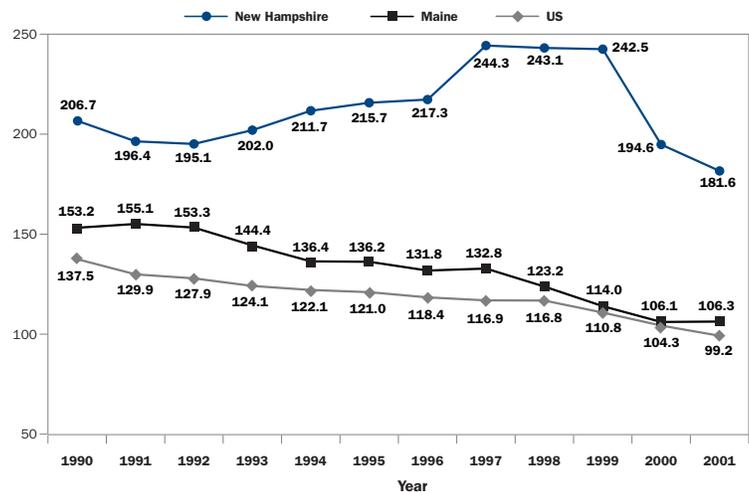
Substance Abuse

- **Reduce tobacco consumption**

Tobacco use is measured by two major statewide indicators – the percent of a population that is addicted, commonly known as smoking rates, and tobacco consumption, which is the packs sold per adult. The early result of effective prevention and treatment interventions is that smokers reduce their overall consumption before a significant proportion of them are no longer tobacco addicted.

Tobacco consumption also drops in response to price hikes. Maine's

Tobacco Consumption Trends In Packs of Cigarettes Consumed Per Adult In Maine, NH, US 1995–2000



2001 data use 2000 population data for Maine.
 Source for NH data: Tax Burden on Tobacco, Historical Compilation, Volume 36, by Orzekowsky and Walker.
 NH does not use intercensal estimates for population, according to NH State Planning Office, partly accounting for abrupt change at 2000.
 Source for Maine data: Maine Revenue Service. (Also published in Tax Burden, etc.) Intercensal population estimates from DHS, BOH, ODRVS.

STATE EXCISE TAXES ON CIGARETTES, PER PACK AS OF 9/02:

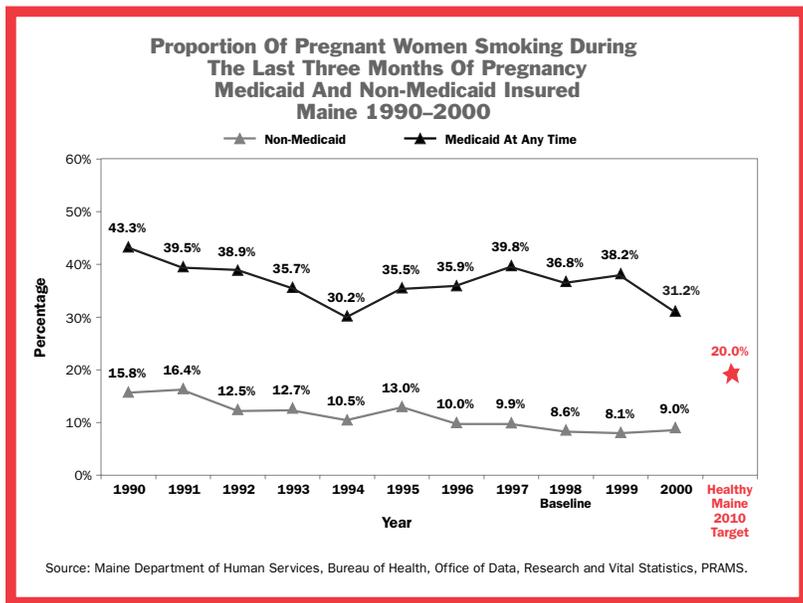
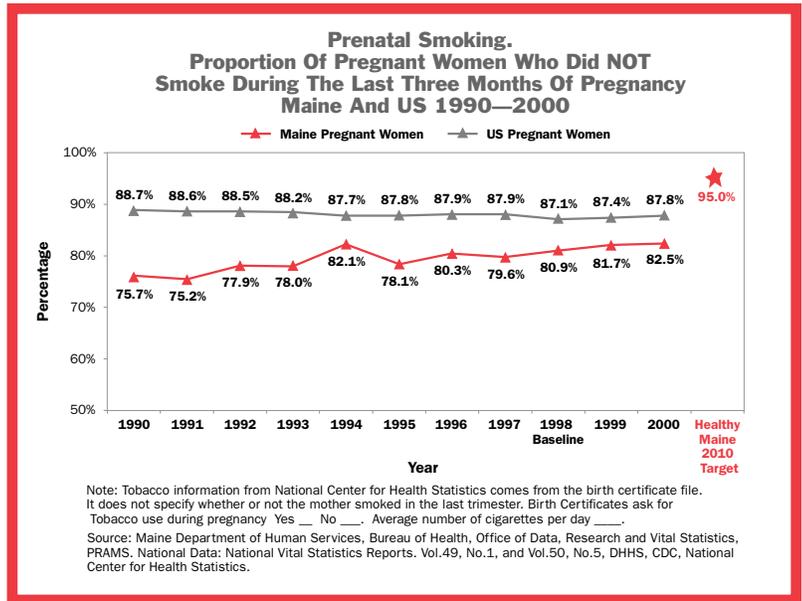
New York	\$1.50
(NYC has an additional \$1.50 per pack)	
New Jersey	\$1.50
Washington	\$1.425
Rhode Island	\$1.31
Michigan	\$1.25
Hawaii	\$1.20
Connecticut	\$1.11
Alaska	\$1.00
MAINE	\$1.00
Maryland	\$1.00
Pennsylvania	\$1.00
Illinois	\$0.98
Vermont	\$0.93
California	\$0.87
Wisconsin	\$0.77
Massachusetts	\$0.76
Kansas	\$0.70
Utah	\$0.695
Oregon	\$0.68
Arizona	\$0.58
Indiana	\$0.555
Ohio	\$0.55
New Hampshire	\$0.52

excise tax increased from 37 cents to 74 cents per pack in November of 1997, then increased to one dollar per pack in October of 2001.

• **27-6 Increase tobacco cessation during pregnancy.**

27-6a Increase the proportion of Maine and US pregnant women who did NOT smoke during the last three months of pregnancy.

Healthy Maine 2010 Baseline: 80.9%
Healthy Maine 2010 Target: 95.0%



27-6b Reduce proportion of low income pregnant women who smoked during the last three months of pregnancy.

Medicaid Insured:
Healthy Maine 2010 Baseline: 36.8%
Healthy Maine 2010 Target: 20.0%

Tobacco use during and after pregnancy is very harmful to babies, and may result in an unhealthy low birth weight, sudden infant death syndrome (SIDS), pneumonia, and asthma in infants. Therefore, effectively helping pregnant women and their partners to quit early in pregnancy has important benefits to the entire family.

One of the leading factors associated with tobacco addiction is low income. Therefore, one of the highest priority populations for prevention and cessation interventions is those Maine people living with low income. Since Medicaid (MaineCare) Insurance is available for many low-income pregnant women, assuring they have access to effective cessation interventions is critical to their well-being and that of their families. Assuring their partners have this access and implementing effective prevention strategies with low income youth and young adults are also important strategies to achieving this objective.



- **26-19 (Developmental) Increase the proportion of youth and adults in the criminal justice system receiving substance abuse treatment in correctional facilities.**

Nationally, criminal offenders frequently have high occurrences of a substance abuse history, have not received treatments; yet without treatment, have a greater likelihood of committing additional criminal offenses.

One-third of all traffic fatalities in Maine are alcohol-related – an average of 62 deaths per year.

- **26-21 (Developmental) Reduce the treatment gap for alcohol and other drug problems.**

Availability of resources and access to clinically appropriate and effective treatment for alcohol problems vary between different areas of the State. This is especially true since effective treatments must be offered in different settings and modalities. For instance, the treatment for someone whose alcohol problem is acute versus intermittent or chronic is usually different. Likewise, the treatment for someone whose alcohol problem is mild is different than for someone whose problem is severe. Assuring access to culturally competent and linguistically appropriate services also is a challenge.

- **26-7 (Developmental) Reduce intentional injuries resulting from alcohol and illicit drug-related violence.**

The Uniform Crime Report lists alcohol and drug offenses (manufacture and possession) and homicides, but does not report homicides or intentional injuries where alcohol or drugs were involved. Therefore, this is a developmental objective.

During a 12-month period, the Maine Injury Prevention Program at the Bureau of Health found that 32% of the individuals who were considered at risk for suicide were using drugs or drinking at the time. This is consistent with national studies on the issue.

Nationally, an estimated 60% of homicide offenders were drinking alcohol when they committed the offense. Other studies reported in *Healthy People 2010* show that those arrestees testing positive for drugs are most often arrested for violent offenses such as robbery, assault, and weapons offenses. Two-thirds of victims who experienced violence by an intimate partner report that alcohol had been involved. And almost one-third of strangers who are victimized believe that the offender used alcohol.

While the good news is that most kids don't drink, alcohol is still the drug of choice for youth both in Maine and around the nation. Thirty percent of Maine students grades 6 through 12 have consumed alcohol in the past 30 days, and that increases to about 49% for 12th graders. (2002 MYDAUS, Maine BDS, Office of Substance Abuse). Youth are at high risk for the detrimental effects of alcohol including cloudy judgment, poor academic achievement, early and unprotected sex, assault, car crashes, suicide, and drownings.

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Substance Abuse

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* Peter	McCorism	AMHC/RTF
* Paul	McDonnell	Milestone
Natalie	Morse	Maine General Health Medical Center
Michelle	Mosher	Maine DHS, Bureau of Health
Diane	Mulkhey	Central Maine Medical Center
Pamela	Nelon	The Women's Project
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Luc	Nya	Maine Department of Behavioral & Developmental Services
* Jeanne	Ogden	OSH
Karen	O'Rourke	Maine Center for Public Health
Sally-Lou	Patterson	Maine DHS, Bureau of Health
Judy	Peary-Adams	University of Maine at Farmington, Community Health Program
Juan	Perez-Febles	Maine Department of Labor
Kristine	Perkins	Maine DHS, Bureau of Health
Bonnie	Post	Maine Primary Care Association
Bill	Primmerman	Maine Department of Education
Jean	Rabon	Central Maine Medical Center – Trauma Program
Janet	Rensink	Central Maine Medical Center, Department of Social Work
* Roger	Richards	Maine Department of Education
Lewis	Rioux	MDI Community Health Plan
Debra	Robertson	University of Maine at Farmington, Community Health Program
Tammy	Rolfé	Maine DHS, Bureau of Health
* Brent	Scobie	Acadia Hospital
Stephen	Sears	Maine General Health Medical Center
Roanne	Seeley	Maine Department of Education
Paul	Shapans	
Sharron	Sieleman	Central Maine Medical Center
Toby	Simon	Portland West
Phillip	Slocum	Martin's Point Health Care
Dawn	Stiphen	CIGNA Healthcare of Maine
* Jeanie	Stone	Child Health Center – Teen Impact
Tina	Streker	
Anne	Summer	
Stephanie	Swan	Maine Department of Education
Wendy	Tardif	Central Maine Medical Center
Andrea	Thompson	Portland Public Health Division
Donna	Thompson	Central Maine Medical Center

First Name	Last Name	Organization Name
Clough	Toppan	Maine DHS, Bureau of Health
Edward	Trainer	Medical Care Development, Inc.
Carol	Troy	The Women's Project – PROP
* Melissa	VanOrman	University of Maine at Farmington
Lisa	Wallace	Maine Department of Behavioral & Developmental Services
Debra	Wigand	Maine DHS, Bureau of Health
Katherine	Wilbur	Maine Department of Education
Bob	Woods	Maine DHS, Bureau of Health

** Members who attended half day Healthy Maine 2010 Substance Abuse Priority Area Work Group meeting.*